



## The Commonwealth of Massachusetts Group Insurance Commission

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Boston, MA 02114-8747

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[www.mass.gov/gic](http://www.mass.gov/gic)

Date:  
Name of Insured (and Spouse, if applicable):  
Address:

### GROUP *DENTAL* CONTINUATION COVERAGE UNDER COBRA

#### ELECTION NOTICE AND APPLICATION

You are receiving this notice because the Group Insurance Commission (GIC) has been informed that your current GIC coverage is ending due either to (1) death of retiree; (2) divorce or legal separation; or (3) loss of dependent child status.

This notice contains important information about your right to temporarily continue your Dental/Vision care coverage in the Group Insurance Commission's (GIC's) Dental/Vision plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the enclosed Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4<sup>th</sup> floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

**WHAT IS COBRA COVERAGE?** COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group Dental/Vision coverage if group coverage otherwise would end due to certain life events. If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit in writing at Group Insurance Commission, P.O. Box 8747, Boston, MA 02114, or by calling the Unit at 617/727-2310, ext. 1. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) for more general information about COBRA.

**WHO IS ELIGIBLE FOR COBRA COVERAGE?** Each individual entitled to COBRA (known as a “Qualified Beneficiary”) has an *independent right* to elect the coverage, regardless whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

**If you are the spouse of a retiree covered by the GIC’s Dental/Vision insurance program,** you have the right to choose COBRA coverage for yourself if you lose GIC Dental/Vision coverage for any of the following reasons (known as “qualifying events”):

- Your spouse dies;
- Your spouse’s employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

**If you have dependent children of an retiree covered by the GIC’s Dental/Vision insurance program,** each child has the right to elect COBRA coverage if he or she loses GIC Dental/Vision coverage for any of the following reasons (known as “qualifying events”):

- The retiree-parent dies;
- The retiree-parent’s employment is terminated (for reasons other than gross misconduct) or the parent’s hours of employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules.

**HOW LONG DOES COBRA COVERAGE LAST?** By law, COBRA coverage must begin on the day immediately after your group Dental/Vision coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other Qualifying Events listed above, you may maintain COBRA coverage for up to 36 months.

Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration’s disability determination within 60 days of your receiving it and before your initial 18 month COBRA period ends in order to extend the coverage.

**COBRA coverage will end before the maximum coverage period ends** if any of the following occurs:

- The COBRA premium is not paid *in full* when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group Dental/Vision plan that does not impose any pre-existing condition exclusion for the qualified beneficiary’s pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group Dental coverage to any of its retirees; or
- Any reason for which the GIC terminates a non-COBRA enrollee’s coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

**HOW AND WHEN DO I ELECT COBRA COVERAGE?** Qualified beneficiaries must elect COBRA coverage within 60 days of the date their group coverage otherwise would end. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

**HOW MUCH DOES COBRA COVERAGE COST?** Under COBRA, you must pay 102% of the applicable premium for your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your premium is 150% of the applicable full cost premium for the additional 11 months of coverage. Premium rates will change periodically. This year's COBRA rates accompany this notice.

**HOW AND WHEN DO I PAY FOR COBRA COVERAGE?** If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

In order to cover you immediately after your current group coverage ends, your first payment pays for 'retroactive premium' you owe for the cost of COBRA coverage from the time your current group coverage otherwise would end up to the time you make the first payment. **You are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments usually are due around the 15<sup>th</sup> of each month. The GIC will send monthly bills for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After you pay for the retroactive premium payment, you will be given a 30-day grace period, beyond the due date on each monthly bill, in which to make each monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to pay the premium before the grace period for that payment ends, you will lose all rights to COBRA coverage.**

#### **YOUR COBRA COVERAGE RESPONSIBILITIES**

- **You must elect COBRA within 60 days from the date you would lose group coverage due to one of the events described above.** If you do not elect COBRA coverage within the 60-day limit, your group Dental/Vision insurance coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment of COBRA'S retroactive premium within 45 days after you elect COBRA.** If you do not make your first payment for the entire retroactive COBRA premium within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly premium for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** You will receive a monthly bill for COBRA coverage, which will specify the due date for the premium charged and the address to which payment is to be sent. If you do not pay the premium in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.

- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The retiree dies;
  - The retiree becomes legally separated or divorced;
  - The retiree or retiree's former spouse remarries;
  - A covered child ceases to be a dependent under GIC eligibility rules;
  - The Social Security Administration determines that you or the retiree is disabled; or
  - The Social Security Administration determines that you or the retiree is no longer disabled.

**If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage.** To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at the Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Retiree Dental Plan Monthly COBRA Rates Effective July 1, 2008		
	Individual \$24.41	Family \$58.79



# Commonwealth of Massachusetts Group Insurance Commission

## Retiree Dental COBRA Application

Name of Applicant: \_\_\_\_\_

Home Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Coverage Termination (if known): \_\_\_\_\_

(Check one): I am the \_\_\_\_ Insured \_\_\_\_ Insured's Dependent (spouse, child)\*

(If dependent)

Name of Insured: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\*all dependents **must** complete information below in order to process application

### **IF YOU ARE A DEPENDENT APPLYING FOR COVERAGE, PLEASE CHECK ALL THAT APPLY**

\_\_\_\_ I am a former spouse of a state insured who

\_\_\_\_ died on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ left state service on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ remarried on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ I remarried on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ I am a surviving dependent of a deceased state insured, and remarried on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ I am a dependent of a state insured and

\_\_\_\_ my parent (the state insured) died on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ my parents legally separated or became divorced on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ I am age 19 to 26 and am no longer eligible for GIC coverage under the GIC's eligibility rules

\_\_\_\_ I am age 26 or over and am not a full-time student

\_\_\_\_ I am a \_\_\_\_ spouse or \_\_\_\_ dependent of a state insured and the Social Security Administration determined that I am \_\_\_\_ disabled or \_\_\_\_ no longer disabled as of \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mail completed form to: GIC, P.O. Box 8747, Boston, MA 02114-8747 Attention: COBRA Unit**

**For GIC Use Only - Do Not Write in This Space**

Insured's Agency/Division: \_\_\_\_\_/\_\_\_\_\_

Coverage Information: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Coverage Termination Reason: \_\_\_\_\_ COBRA Agency/Division: \_\_\_\_\_

COBRA effective date: \_\_\_\_\_ Expiration date: \_\_\_\_\_